Dept. Health, Soc., & Welfare
U. S. Public Health Service

V. S. 300
Rev. 1-57

FILED DEC 9 - 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

40145
STATE FILE NUMBER

Registration District No. 143 Primary Registration District No. 55 61 Registrar's No.

1. PLACE OF DEATH
a. COUNTY Howell
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Pine Brook Rest Home — Length of stay in 1b
d. STREET ADDRESS (If outside, give location)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Douglas
c. CITY OR TOWN Coldsprings — Inside Limits Yes ☐ No ☒
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First John Middle Last Lakey

4. DATE OF DEATH Month 11 Day 27 Year 1957

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH 1-6-1892

9. AGE (In years last birthday) 65 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY Own Farm

11. BIRTHPLACE (City and state or country) Douglas County, Mo

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME William Lakey

13b. MOTHER'S MAIDEN NAME Matilda Carter

14. NAME OF HUSBAND OR WIFE Ida Hale

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT Mrs James Liles Address R. 3 - Box 1083 Springfield, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 2 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral arteriosclerosis — 10 years
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 332X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 11/6/57 to 11/6/57 and last saw ~~her~~ him alive on 11/6/57
Death occurred at m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) M. L. Fowler MD

22b. ADDRESS West Plains Mo

22c. DATE SIGNED 12/2/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 12-1-1957

23c. NAME OF CEMETERY OR CREMATORY Fannon Cemetery

23d. LOCATION (City, town, or county) (State) Ava R. Mo.

24. FUNERAL DIRECTOR ADDRESS Clark Ringhead Funeral Home Ava Mo.

25. DATE RECD. BY LOCAL REG. 12-9-57

26. REGISTRAR'S SIGNATURE Thomas C Duncan

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Charles R. Fish

Licensed Embalmer No. 4662

P. O. Address Aurora, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.